



IDAHO FLEX PROGRAM

rural health plan

2008 - 2009



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2008-2009

INTRODUCTION

The Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, conducted a Medicare Rural Hospital Flexibility Program (Flex Program) rural health planning session on November 8, 2007, with state Flex Program stakeholders. The one-day session included an overview of national and state Flex Program activities, presentation of Flex Program related data and activities outcomes information, discussions related to Idaho's rural health issues and potential solutions, as well as a solution prioritization process.

The intent of the program planning session was to:

- 1) continue to engage Idaho rural health stakeholders in the rural health planning process,*
- 2) further develop participants' understanding of the Flex Program,*
- 3) discuss state rural health issues, in particular those related to Critical Access Hospitals (CAHs) and the communities they serve,*
- 4) update the Idaho Rural Health Plan, and*
- 5) identify activities to include as part of the 2008 – 2009 Idaho Flex Program.*

Program planning participants included representatives of: networks, Office of Rural Health and Primary Care, Emergency Medical Services (EMS) Bureau, CAHs, Idaho Hospital Association (IHA), and networks. Rural Health Solutions, a rural health and health workforce research and program development firm located in St. Paul, Minnesota, facilitated the discussion.



RURAL IDAHO AND IDAHO RURAL HEALTH SERVICES

Located in the Pacific Northwest, Idaho is predominantly a rural state. Nationally, it is ranked 14th in terms of its geographic area (83,642 square miles) and 39th in terms of its population size (1,429,096 in 2005) (Source: US Census Bureau). Between 2004 and 2005 it was the 3rd fastest growing state in the nation. Idaho can be characterized as having vast mountain, desert, and agricultural areas that are sparsely populated with heavily traveled two-lane highways. It also has many recreation areas that experience large population increases during winter and summer months with newly emerging recreation areas, no medical school, an EMS system that has few hospital-based providers, two time zones, and a predominantly rural remote hospital infrastructure.



Idaho's hospitals consist of 37 acute care hospitals, four specialty care hospitals, six psychiatric hospitals, one rehabilitation hospital, one Veterans Administration hospital, and one Air Force hospital. Rural hospitals are scattered throughout the state while urban hospitals are located in the Boise metropolitan area, Coeur d'Alene, Idaho Falls, Lewiston, and Pocatello. There are 26 CAHs in Idaho: 10 are more than 35 miles from the next nearest hospital, four are more than 15 miles from the next nearest hospital in mountainous terrain or in areas with only a secondary road, and 12 meet the necessary provider criteria in the state.

Idaho's EMS system consists of 199 licensed EMS agencies that predominantly provide Basic Life Support Services. Like rural hospitals, they are scattered throughout the state and they serve very remote areas with varying geographic terrain. Some rural EMS squads have service response areas that are up to 7,000 square miles.





MEDICARE RURAL HOSPITAL FLEXIBILITY (FLEX) PROGRAM

The Medicare Rural Hospital Flexibility Program (Flex Program) was established through the Balanced Budget Act of 1997. It is a national program that includes 45 states, including Idaho. In essence, the Flex Program is comprised of two components – grants to assist states in implementing state specific program activities and an operating program that provides cost-based Medicare reimbursement to hospitals that convert to CAH status. The U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration, federal Office of Rural Health Policy, administers the grant program, while the operating component of the program is administered by the Centers for Medicare and Medicaid Services (CMS), also located within DHHS.

Six Flex Program priority areas have been established for states implementing the program, they are¹:

- 1 Creating and implementing a state Rural Health Plan
- 2 Designating and supporting CAHs
- 3 Fostering and developing rural health networks
- 4 Enhancing and integrating Emergency Medical Services (EMS)
- 5 Improving the quality of health care
- 6 Evaluating Flex Program activities and related outcomes

IDAHO FLEX PROGRAM

The Idaho Flex Program is managed by the Idaho Department of Health and Welfare (IDHW), Office of Rural Health and Primary Care. During the past nine years, the Idaho Flex Program obtained **\$4,583,400** or an average of **\$509,267** per year from the Health Resources and Services Administration, Office of Rural Health Policy, to implement the Flex Program in Idaho. There are **26** CAHs in Idaho, which make up **70** percent of acute care hospitals in the state. All CAHs receive technical assistance and/or financial support on an annual basis through Idaho's Flex Program.

mission:

The Idaho Flex Program supports collaboration among healthcare entities to capitalize on resources, avoid duplication of activities, and enhance the integration of services. Program stakeholders work as partners to develop and incubate best practices to assure viability and access to high quality healthcare services.

As a part of the current Flex Program grant year (2007-2008), funding is being directed to:

- **Office of Rural Health and Primary Care (67%)**
 - Sub contractual agreements with CAHs and other local and regional stakeholders (62%)
 - CAH conferences, workshops, and travel costs (19%)
 - Program administration/planning costs (13%)
 - Program evaluation (6%)
- **Idaho Hospital Association (33%)**
 - Conduct quality improvement in-services, credentialing and quality assurance reviews, and network meetings
 - Support the CAH Quality Improvement Subcommittee
 - Subsidize CAH participation in Databank and the peer review network
 - Support the development of cultural competency policies and procedures in CAHs
- **State EMS Bureau (supported through 2007 Flex Program carry-over funding)**
 - EMS medical director training

goals:

- Foster collaboration among CAHs, EMS, and other community health care providers.
- Support initiatives that improve quality across the continuum of care.
- Work toward a sustainable and financially viable rural health care services infrastructure.
- Promote the sharing of resources, expertise, and best practices.
- Establish grant programs that support the implementation of electronic medical records, new programs, and best practices.
- Eliminate the redundancy of services/programs available throughout the Flex Program, networks, and IHA.
- Eliminate redundancy and unnecessary data collection and reporting activities.
- Support the integration of health services across the continuum of care with a focus on pre-hospital and hospital care.

These goals were developed as part of the 2005 Idaho Flex Program's rural health planning process and were revisited as part of the rural health planning process in 2007. Stakeholders continue to support this set of goals for the Idaho Flex Program.



2008 – 2009 RURAL HEALTH PLANNING PROCESS & OUTCOMES

The Idaho Flex Program planning session was held November 8, 2007, in Boise, Idaho. Thirty-one Flex Program stakeholders participated in this process. The day consisted of reviewing Idaho's Flex Program, the program nationally, and other state programs; discussing Flex Program participation and CAH financial data; identifying on-going rural health issues related to EMS, networking, quality improvement, and CAHs; and discussing activities that may contribute to solving the identified rural health issues. The group identified a list of 30 rural health issues and a list of 25 potential solutions/activities to resolve the issues. They further discussed and refined the list of 25 solutions, verifying that the list reflected the state's Flex Program mission and goals, and merged the list with the activities being completed as part of the 2007 – 2008 grant year to create a master list of potential solutions/program next steps. Considering all activities on the master list, participants voted (10 votes per participant) for the activities they believe should be the highest priority for inclusion in Idaho's Rural Health Plan to advance the state Flex Program.

Below is the list of rural health issues as well as the initial corresponding solutions. This is followed by the final prioritized master list of solutions/activities that reflect Idaho's project plans for the 2008 – 2009 grant year:

RURAL HEALTH ISSUES AND INITIAL SOLUTIONS

ems

ISSUES:

- Lack of training for EMS medical directors, leadership, and emergency room physicians
- Recruitment and retention of EMS volunteers
- Lack of quality improvement programs for EMS
- Lack of local level EMS strategic planning
- Financial viability of some local EMS agencies
- Lack of training opportunities to maintain clinical competencies (e.g., pediatric and obstetric), particularly given the low patient volume for many local EMS agencies
- Lack of staff to complete ground transports from CAHs to tertiary centers



SOLUTIONS:

- Support opportunities for joint CAH and local EMS training
- Investigate opportunities to merge local EMS agencies to obtain Medicare cost-based reimbursement
- Provide technical assistance and support for the establishment of EMS taxing districts
- Develop a means to allow students under the age of 18 to register for the National Registry Test for EMS
- Provide budgeting and leadership training for local EMS agencies
- Establish pilot programs to meet the new EMS national scope of practice requirements

network_{DEVELOPMENT}

ISSUES:

- Limited sharing of best practices among networks and CAHs
- Lack of coordination/not leveraging resources of rural health organizations in the state
- Lack of understanding on where to find key rural health information



SOLUTIONS:

- Continue to support the “network of networks” meeting that is being hosted by the Office of Rural Health and Primary Care as part of the Idaho Flex Program
- Include sharing of best practices as part of the regional networks’ monthly conference calls
- Develop and establish communication tools to educate and inform CAHs and networks on the activities of state Flex Program stakeholders
- Establish a repository for reporting rural health project outcomes and best practices

quality IMPROVEMENT

ISSUES:

- Lack of consistency when CAHs report quality measures to the CAH Quality Improvement website
- Lack of definitions for the quality measures reported to the CAH Quality Improvement website which is resulting in interpretation and inconsistency of data reported by CAHs
- CART (CMS Abstraction and Reporting Tool) is time consuming, difficult to use, and requires extensive staff resources if used
- Redundancy in quality improvement data collection activities
- On-going medication errors
- Lack of staffing to support social work activities in CAHs
- On-going emergency care management issues

SOLUTIONS:

- Collect data on fewer indicators so more data is reported
- Establish clear and well defined definitions of each quality measure
- Identify states where a large number of CAHs are participating in Hospital Compare and determine why their hospitals are not having issues with the CART tool



rural health PLANNING

ISSUES:

- Lack of involvement by local EMS in the rural health planning process
- Lack of input/representation from key geographic areas of the state
- Lack of engagement by the smallest rural hospitals in the Flex Program planning process
- Limited knowledge of the roles and activities of the rural health stakeholder organizations in the state
- Limited knowledge about the activities, accomplishments, and best practices of other state Flex Programs around the U.S.



SOLUTIONS:

- Obtain rural health EMS planning information by attending and soliciting input as part of regularly scheduled state and regional EMS events
- Use EMSAC (Emergency Medical Services Advisory Committee) as a means to gather information from local, regional, and state EMS to include in the planning process
- Host regional planning meetings to obtain broader input from local and regional EMS stakeholders
- Include EMS Flex Program planning information as part of the annual state Flex Program planning meeting and incorporate it into the state rural health plan
- Establish a state, rural health communication, web based tool as part of the Idaho Rural Health Association



ISSUES:

- Health workforce recruitment and retention
 - Need for wage analysis comparing Idaho to the nation
 - Staff shortages: registered nurses, physicians, pharmacists, physician specialists, medical technicians, laboratory technicians, physical therapists, occupational therapists, radiology technicians
 - Lack of tools and other mechanisms to expose students to health care environments
 - Lack of clinical instructors to train those obtaining a degree in health care
- Limited access to specialty services
- Limited access and likely increasing need for improved access to outpatient chemotherapy services
- Lack of/slow to establish health information technology (e.g., telemedicine and electronic health record) in rural communities
 - Lack of technical staff
 - Limited buy-in from medical staff and other staff
 - High cost
 - Reimbursement for telemedicine
 - Staff have limited skills in the use of information technology
- Limited access to capital for hospital re-build, expansion, and renovation projects
- Difficulty accessing Rural Health Clinic designation
- Difficulty accessing federal student loan repayment funds
- Fiscal intermediary that is not responsive to CAH issues
- Financial viability of some CAHs



SOLUTIONS:

- Some high school health care recruitment programs are working in the state. They could be identified and serve as models for other communities
- Develop and fund a state health occupations loan repayment program
- Encourage collaboration among CAHs to further develop health information technology
 - Sharing of best practices
 - Joint meetings (planning, implementation, training)
- Support the development and use of telemedicine to address key access issues in CAH communities (pharmacy, mental health, and specialty services)
- Train CAH staff and physicians in information technology
- Host a statewide health information technology summit
- Support CAH leadership/management training



PRIORITIZED ACTIVITIES:

**Activities are ranked according to stakeholder support, () indicates the number of votes each activity received from stakeholder participants, and bolded items received 10 or more votes.*

ems

- **Establish local EMS National Scope of Practice pilot projects in CAH communities** – the pilot projects will address the need and challenges for local EMS agencies to meet the new National Scope of Practice requirements **(20)**
- **Identify examples/models of merged EMS agencies in other states that resulted in meeting the 35 mile distance criteria and ultimately providing cost-based reimbursement for CAH-based EMS agencies** **(16)**
- **Support on-going mobile human simulator lab training for local EMS and CAH staff working in CAH communities** **(13)**
- **Support opportunities for CAH staff to be trained in the Comprehensive Advanced Life Support (CALS) program and/or the Rural Trauma Team Development (RTTD) course** **(10)**
- **Support EMS medical director training that would jointly train and meet the needs of EMS medical directors, EMS managers, and emergency room physicians** - this will include a stipend to offset the cost of participation) **(10)**

- Contact CAHs and local EMS agencies to identify best practices for inter-facility transfers (7)
- Develop and support an EMS Quality Improvement project – This is intended as a pilot project consisting of a small number of CAHs with hospital-based and independent ambulance services that would engage in planning, EMS indicator identification, training, and IT development. This pilot project would have elements of and be modeled after the CAH Quality Improvement Collaborative (4)
- Develop a pre-conference, EMS leadership and budgeting training workshop that would be held in conjunction with the state EMS conference (2)
- Provide information and technical assistance to local EMS agencies that are interested in creating EMS taxing districts (0)

network DEVELOPMENT

- **Continue support for the “network of networks” meetings but establish a clearly defined agenda and goals for the meeting, meet quarterly, and report meeting information to Flex Program stakeholders** - all stakeholders agreed this should continue to be a priority of the Flex Program

quality IMPROVEMENT

- **Develop and make available quality improvement training opportunities for CAHs’ board members and tools for CAH leadership to share quality improvement information with board members, staff, and others (21)**
- **Host a statewide CAH Quality Improvement meeting that includes CAH Quality Improvement Coordinators, other CAH leadership, Qualis Health (the state Quality Improvement Organization), and others to refine the CAH Quality Improvement website, discuss and address issues related to Hospital Compare and the CART tool, and to learn about best practices in other states (18)**
- **Query CAHs to identify the CAHs that have successful protocols for patient mental health holds and share the protocols with all CAHs (13)**
- **Continue the CAH Quality Improvement data collection project through the Idaho Hospital Association (13)**
- **Support on-going CAH peer review network activities (11)**
- **Support on-going, on-site, CAH QI in-services activities (10)**
- Support on-going, on-site, CAH quality assurance/credentialing review activities (0)
- Support on-going, CAH memberships in Databank (0)



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- **Conduct regional Flex Program planning meetings that include representatives of local EMS and CAHs and incorporate this information into the state Flex Program planning process** - all stakeholders agreed this should be a priority of the Flex Program



cah SUPPORT

- **Support community needs assessments in CAH communities** – needs assessments would be similar to the EMS needs assessments conducted as hospitals converted to CAH status and would include service (e.g., chemotherapy) and physical plant related needs (20)
- **Make available on-going sub-contractual agreements to support EMS, networking, and quality improvement activities in CAHs** - approximately \$4,000 available to each CAH annually (19)
- **Make available on-going Idaho Flex Program sub-contractual agreements with CAH and EMS organizations located in a CAH community to support EMS, networking, and quality improvement activities in CAH communities** – approximately \$25,000 each to four organizations annually (19)
- **Host a statewide HIT summit that includes CAHs and rural health clinics** (10)

PROGRAM PLANNING PARTICIPANTS:

Facilitator:

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Flex Program Stakeholders:

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PROGRAM RURAL HEALTH PLANNING *next steps:*

Flex Program staff in the Idaho Office of Rural Health and Primary Care will obtain additional program planning input from CAH administrators and other stakeholders to complete the rural health planning process. This input will further assist the Office of Rural Health and Primary Care with determining Idaho's Flex Program plans for the 2008-2009 grant year.

ADDITIONAL INFORMATION:

If you have questions about the Idaho Flex Program or the Office of Rural Health and Primary Care, please contact Mary Sheridan, Director at **208/334-0669** or via e-mail at ruralhealth@dhw.idaho.gov.

You can find the Office of Rural Health and Primary Care on the Web at

www.ruralhealth.dhw.idaho.gov



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